

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13614

CERTIFICATE OF DEATH

13605

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
3. NAME OF DECEASED (Type or print) <u>FRED</u>		First <u>W.</u>	Middle <u>Beiswanger</u>
4. DATE OF DEATH <u>Dec. 18 1958</u>	Month <u>Dec.</u>	Day <u>18</u>	Year <u>1958</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30, 1877</u>
9. AGE (In years last birthday) <u>80</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. IF UNDER 24 HRS. Hours <u>0</u>
13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Stationery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>John Beiswanger</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Weber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>097-03-8078</u>	
17. INFORMANT <u>Mrs. Fred Beiswanger, Chesapeake</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Cardiac vascular disease</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chesapeake City</u>
20f. (City or town) <u>Chesapeake City</u>		(County) <u>Md.</u>	
(State) <u>Md.</u>			
21. I certify that I attended the deceased from <u>None</u> , 19 <u>58</u> , to <u>Dec 18, 1958</u> , that I last saw the deceased alive on <u>Dec 18, 1958</u> , and that death occurred at <u>659</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chesapeake City Md.</u>			
ACTUAL SIGNATURE <u>Henry V. Davis MD</u>		DATE SIGNED <u>13 Dec 58</u>	
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/58</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Bethel Cem.</u>
22d. LOCATION (City, town, or county) <u>Bethel</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter de Rose, Jr.</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knott</u>
ADDRESS <u>Elkton, Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar privately, serial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18										13605				
13628 CERTIFICATE OF DEATH										Reg. Dist. No. 96				
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington									
d. LENGTH OF STAY IN 1b 18 days					d. STREET ADDRESS 1427 Irving Street, N.E.									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First LEWIS	Middle M.	Last BIVINS	4. DATE OF DEATH December 2 1958	Month December	Day 2	Year 1958						
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1912	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk					10b. KIND OF BUSINESS OR INDUSTRY Postal					11. BIRTHPLACE (State or foreign country) Georgia				
13. FATHER'S NAME Henry C. Bivins					14. MOTHER'S MAIDEN NAME Carrie L. Bivins					12. CITIZEN OF WHAT COUNTRY? USA				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. WW II					17. INFORMANT Hospital Records, VAH, Perry Point, Md.				
										Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning										3 weeks				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular renal disease										DUE TO				
(c)										DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										DUE TO				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from November 14, 1958 , to December 2, 1958 , and that death occurred at 10:40 AM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) McGuire Fun. Services, 1820-9½ St. N.W. Wash. DC DATE SIGNED 12-2-58				
ACTUAL SIGNATURE <i>W. M. Harris</i>		M.D. V.A. Hospital, Perry Point, Md. 12-2-58												
PHYSICIAN'S NAME (Type) W. M. HARRIS		Acting Director, Professional Services												
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 18.5.58		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National			22d. LOCATION (City, town, or county) Ft Myer, Virginia. (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sergeant McGuire</i>		ADDRESS McGuire Fun. Services, 1820-9½ St. N.W. Wash. DC		24a. REC'D BY REGISTRAR DEC 5 '58			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traub</i>							

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to cause belief that	Intentional manipulation creates	
replies	distortion	
by	of the lies	object
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and/or	Intend	are to
and/or	not to be given	
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1. **Geometria** - **Analiza matematică** - **Algebra**
2. **Geometria** - **Analiza matematică** - **Algebra**
3. **Geometria** - **Analiza matematică** - **Algebra**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13607

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.		c. LENGTH OF STAY IN 1b 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle Lawrence	Last Blevens Jr	4. DATE OF DEATH	Month 12	Day 26	Year 19 35 8
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-10-58	9. AGE (In years last birthday) yrs. 7	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or Foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Lawrence Blevens				14. MOTHER'S MAIDEN NAME Janet Brumit			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no						James L. Blevens, North East, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R.C. Dodson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-29-58				
EXAMINER'S NAME (Type) R.C. Dodson	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-31-58	22c. NAME OF CEMETERY OR CREMATORIAL Methodist	22d. LOCATION (City, town, or county) North East, Cecil Co., Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Josper R. Grant</i>		ADDRESS <i>North East</i>	24a. REC'D BY REGISTRAR DEC 31 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Knoblauch</i>			

11-20000-90000-00000 STATE DIVISION
HARDOE COUNTY GRAYMAUL JACKSON

11-20000

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13608

**FOR STATE
HEALTH DEPT.**

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health in its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13615 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Penna. b. COUNTY Phila.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) D.O.A. Elkton		c. LENGTH OF STAY IN lb Enroute	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NATHANIEL		First L.	Middle BROWN
4. DATE OF DEATH	Month Dec.	Day 24,	Year 1958
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/1930
9. AGE (In years last birthday) 28 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		
11. BIRTHPLACE (State or foreign country) Charleston, S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sam Brown		14. MOTHER'S MAIDEN NAME Wilhelma No Info.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No	
17. INFORMANT Address Charletta Brown Phila, Penna.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		3 in. Laceration of forehead	
822X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Crushed Right Side of Chest	
DUE TO		(c) Crushed Femur	
INTERVAL BETWEEN ONSET AND DEATH 5 Min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Over-turn of truck	
20c. TIME OF INJURY Hour 3:45 P.M.	Month, Day, Year 12/24/58	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) StreetRt. 40 North East Cecil Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R. C. Dodson</i>		DATE SIGNED Dec. 25, 1958	
EXAMINER'S NAME (Type) R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Dec. 25, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Elkton, Md.		22d. LOCATION (City, town, or county) Phila. Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS <i>114 N. Main St. Elkton, Md.</i>	24a. REC'D BY REGISTRAR DEC 29 1958
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13616 CERTIFICATE OF DEATH

Reg. Dist. No. **13609**

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cecilton		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First DAVID	Middle P.	Last DAVIS Sr.	4. DATE OF DEATH December 10, 1958	Month December	Day 10	Year 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH September, 2, 1897	9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lambert W. Davis				14. MOTHER'S MAIDEN NAME Myra Cox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 217-36-4917 Mrs. Grace Davis,		Address Cecilton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Flu DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic nephritis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 3 days 3 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 10, 1958 , to Dec. 10, 1958 , that I last saw the deceased alive on Dec. 10, 1958 , and that death occurred at 850A M , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD							
ACTUAL SIGNATURE Henry V. Davis DATE SIGNED 12/10/58							
PHYSICIAN'S NAME (Type) Henry V. Davis MD		22d. LOCATION (City, town, or county) Earleville, Cecil Co. Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Stephens Cem.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Gillows, Wellington, Md.		ADDRESS ADDRESS		24a. RECD BY REGISTRAR DATE DEC 15 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

RE BROMPTON ROAD TO THAMESIDE STATE MALLARD

HABO RO STADIUM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Ite. 9 filmG237 1-15-39 et
13630 CERTIFICATE OF DEATH

13610

Rag. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Cleveland		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1884	9. AGE (In years lost birthday) 72 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME William T. Etherington				14. MOTHER'S MAIDEN NAME Louise Rossell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Ella Kernan Cecilton Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) severe arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Two previous coronary occlusions and very poor myocardium								
19. INTERVAL BETWEEN ONSET AND DEATH 10 min								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from June 28 Dec 1958 , to 28 Dec 1958 , that I last saw the deceased alive on 28 Dec 1958 , and that death occurred at 10:30 M , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
DATE SIGNED 30 Dec 58								
ACTUAL SIGNATURE Wallace Obenshain M.D.								
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 31, 58		22c. NAME OF CEMETERY OR CREMATORIUM Cecilton Cemetery		22d. LOCATION (City, town, or county) Cecilton Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Edward Ellsworth Millington Jr.		ADDRESS Edwards Ellsworth Millington Jr.		24a. REC'D BY REGISTRAR DALEIN 5 '59		24b. REGISTRAR'S SIGNATURE Edwards Ellsworth Millington Jr.		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13617 CERTIFICATE OF DEATH

13611

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Cecil</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Cecil</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eltton</i>		c. LENGTH OF STAY IN lb <i>6 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Warwick</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hosp.</i>		d. STREET ADDRESS <i>Main St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>David Michael Forester</i>		First	Middle	Last	4. DATE OF DEATH <i>Dec 21 1958</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 4, 1958</i>	9. AGE (In years lost birthday) yrs <i>6</i>	IF UNDER 1 YEAR Months <i>6</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <i>Eltton, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Franklin D. Forester</i>		14. MOTHER'S MAIDEN NAME <i>Mary Keston</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT <i>Franklin D. Forester, Warwick, Md.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Aspiration Pneumonia</i>		DUE TO <i>Amyotonia Congenita</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>491X</i>		(c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>491X</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20e. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Cecilton, Md.</i>		(County) <i>Cecilton</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>June 4, 1958</i> to <i>Dec 21, 1958</i> , that I last saw the deceased alive on <i>21 Dec 1958</i> , and that death occurred at <i>2:00 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Cecilton, Md.</i>		DATE SIGNED <i>21 Dec 1958</i>		
ACTUAL SIGNATURE <i>Wallace Shenklein MD</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/23/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Eltton</i>		22d. LOCATION (City, town, or county) <i>Eltton</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Worthen, Jr.</i>		ADDRESS <i>Eltton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 29 '58</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. S. Trans</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

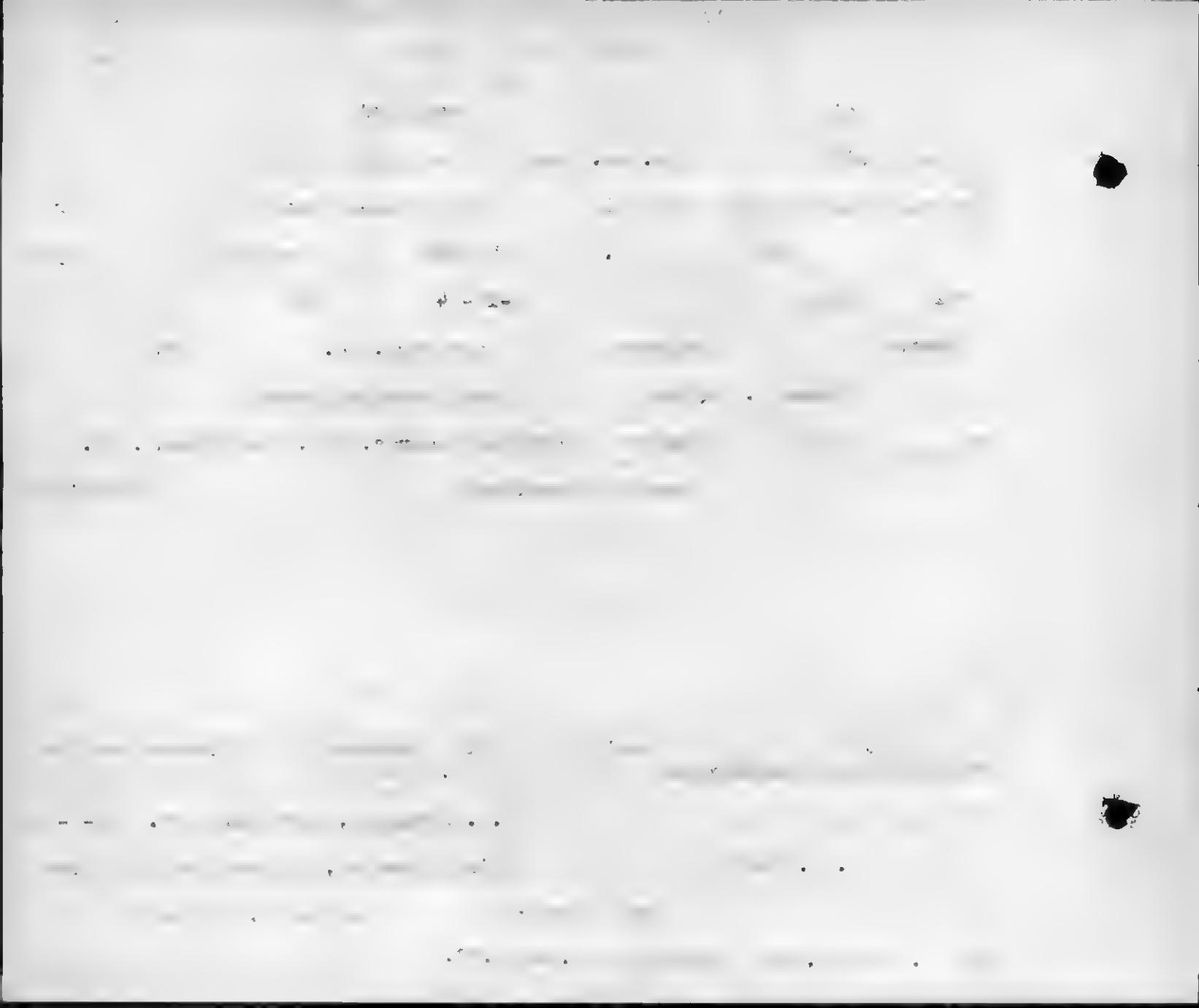
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13631

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

13612
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 27 yrs. 7 mo. 12 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First JOHN	Middle R.	4. DATE OF DEATH HAYDEN Month December Day 3 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-94	
9. AGE (In years lost birthday) 64 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Riveter	11. KIND OF BUSINESS OR INDUSTRY Shipyard	12. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Thomas J. Hayden	14. MOTHER'S MAIDEN NAME Mary Loretta Tansey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes	16. SOCIAL SECURITY NO. WW I	17. INFORMANT Unknown	Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis				
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 1A	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) (State)
21. I certify that I attended the deceased from April 21, 1931 to December 3, 1958 , and that death occurred at 8:45 PM , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>W. M. Harris</i>	ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 12-4-58			
PHYSICIAN'S NAME (Type) W. M. HARRIS	22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 12/6/58	22b. DATE THEREOF 12/6/58	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HARRY H. WITZKE, 4101 Edmondson Ave. Balto. Md.	ADDRESS 5101 Edmondson Ave. Baltimore, Md.	24a. REC'D BY REGISTRAR DEC 5 '58	24b. REGISTRAR'S SIGNATURE Caroline S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13013

13632 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE NEW JERSEY		b. COUNTY BURLINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) PERRY POINT		c. LENGTH OF STAY IN lb 5yrs 8mos 22days		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) BORDENTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 33 Mary Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHERINE		First I.	Middle HERRON	4. DATE OF DEATH December 24	Month	Day 19	Year 58
5. SEX Female White		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-22-84	9. AGE (In years lost/birthday) 74 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Hours M.n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospitals		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW-II		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records, VAH., Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Part I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.0 DUE TO Bronchopneumonia, rt. lower lobe unresolved.						INTERVAL BETWEEN ONSET AND DEATH 6-7 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X		(b) DUE TO Arteriosclerotic Heart Disease, severe.				Unknown	
(c)							
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, Generalized, Severe.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that /VA/ attended the deceased from April 3, 1953, to December 24, 1958, and that death occurred at 5:20 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE R. BURKE SUITT, M.D.						DATE SIGNED 12-26-58	
PHYSICIAN'S NAME (Type)		R. BURKE SUITT, M.D., Acting Director, Professional Services					
22o. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 12-26-58		22c. NAME OF CEMETERY OR CREMATORIUM St Mary's Cemetery		22d. LOCATION (City, town, or county) Bordentown, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE BENJAMIN J. SON, Jr.		ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DEC 29 '58		24b. REGISTRAR'S SIGNATURE	

HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the Hospital or attending Physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2
 be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13614

13633 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Cecil		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Martin	Middle 	Last Isaacs	4. DATE OF DEATH	Month 12	Day 26	Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7 1876	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Penna R.R. Trackman		10b. KIND OF BUSINESS OR INDUSTRY Ret 17 yrs		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Carey Isaacs			14. MOTHER'S MAIDEN NAME Sarah Williams					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO		17. INFORMANT		Address Howard B. Isaacs North East, Md		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Coronary Thrombosis</i> Generalized Artherosclerosis (c) DUE TO — —</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)</p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
<p>21. I certify that I attended the deceased from <i>26 Dec</i>, 19<i>58</i>, to <i>26 Dec</i>, 19<i>58</i>, that I last saw the deceased alive on <i>26 Dec</i>, 19<i>58</i>, and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above.</p> <p>ACTUAL SIGNATURE <i>Elmer H. Huebner</i> M.D. ADDRESS (Street, city or town, state) <i>North East, Md.</i> DATE SIGNED <i>26 Dec 1958</i></p> <p>ENTITLED NAME (Type) <i>Elmer H. Huebner A.D.</i></p>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-1958		22c. NAME OF CEMETERY OR CREMATORIUM Ebenezer Methodist		22d. LOCATION (City, town, or county) (State) Rising Sun Rd Cecil Co., Md		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DEC 31 '58		24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>		



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained by the hospital or attending physician.

VS AISC 1-55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

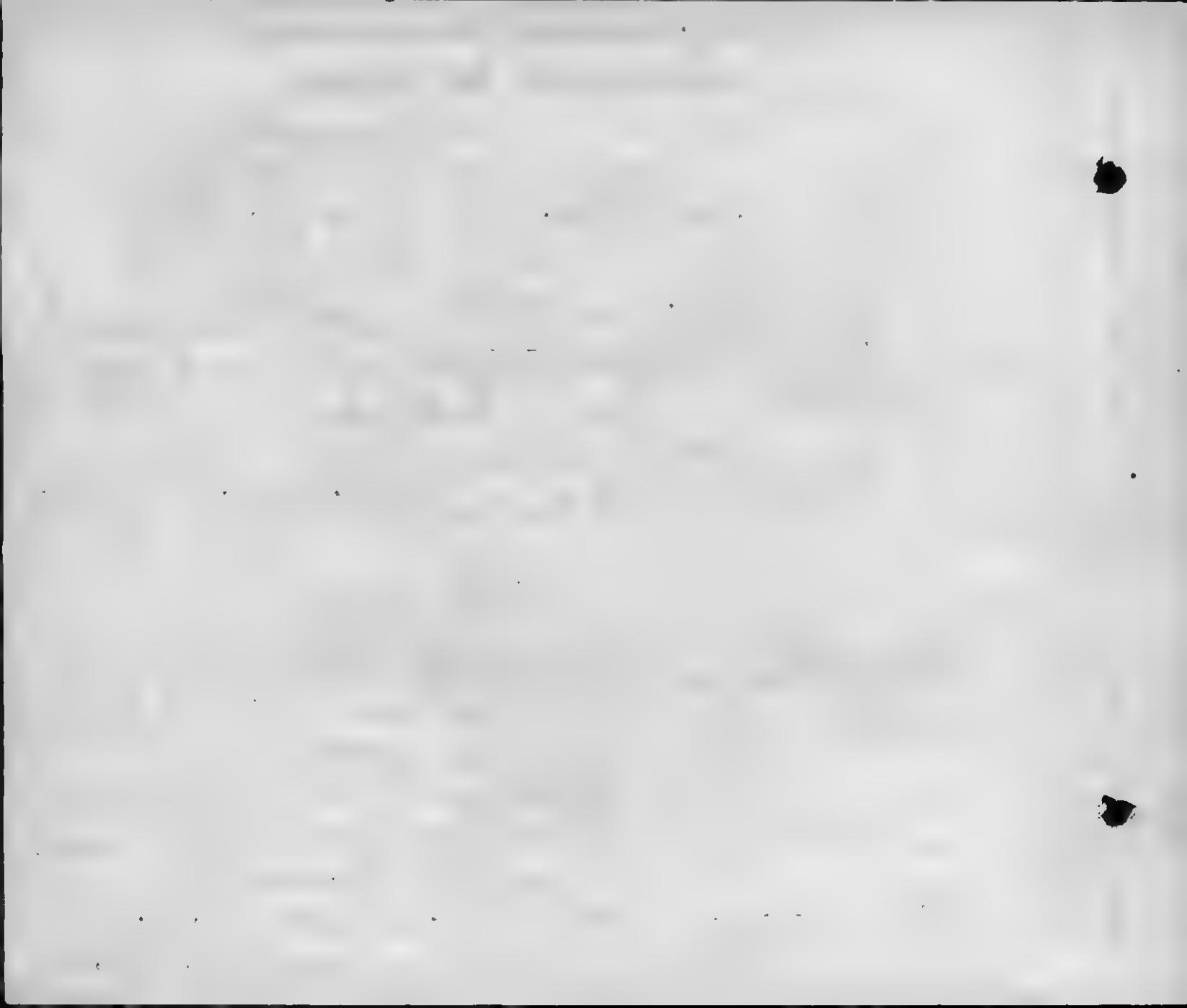
13615

13634

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY Cecil MARYLAND CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Port Deposit, Rural LENGTH OF STAY (In this place) 40 Yrs.			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Port Deposit, Rural STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (Type or Print) Frances E. Jackson			4. DATE (Month) OF DEATH 12 31 58		
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 12-17- 1890	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months 0 Dey 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house Wife			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Patrick Murphy			14. MOTHER'S MAIDEN NAME Hannah Hickey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Chester S. Jackson. Port Deposit, Md	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4. 1 IMMEDIATE CAUSE (A) Coronary Occlusion ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Coronary Stenosis GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Myocarditis INTERVAL BETWEEN ONSET AND DEATH 2 days 3 1/2 yrs days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) Baltimore, Md (State) Md	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 19 1958		21e. INJURY OCCURRED M. <input type="checkbox"/> While at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? fall from bed	
22. I hereby certify that I attended the deceased from Dec 19 1958 , to Dec 31 1958 , that I last saw the deceased alive on Dec 30, 1958 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. NATURE Frances E. Jackson M.D. ADDRESS (Street, city, town, state) Port Deposit, Md DATE SIGNED 1/1/59					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-3-1959	NAME OF CEMETERY OR CREMATORIUM Brookview Cemetery	LOCATION (City, town, or county) Rising Sun, Md.	
24. REC'D BY REGISTRAR DATE JAN 5 '59		REGISTRAR'S SIGNATURE John S. Kuhn			
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lee L. Patterson, Son, Perryville, Md					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13635 CERTIFICATE OF DEATH

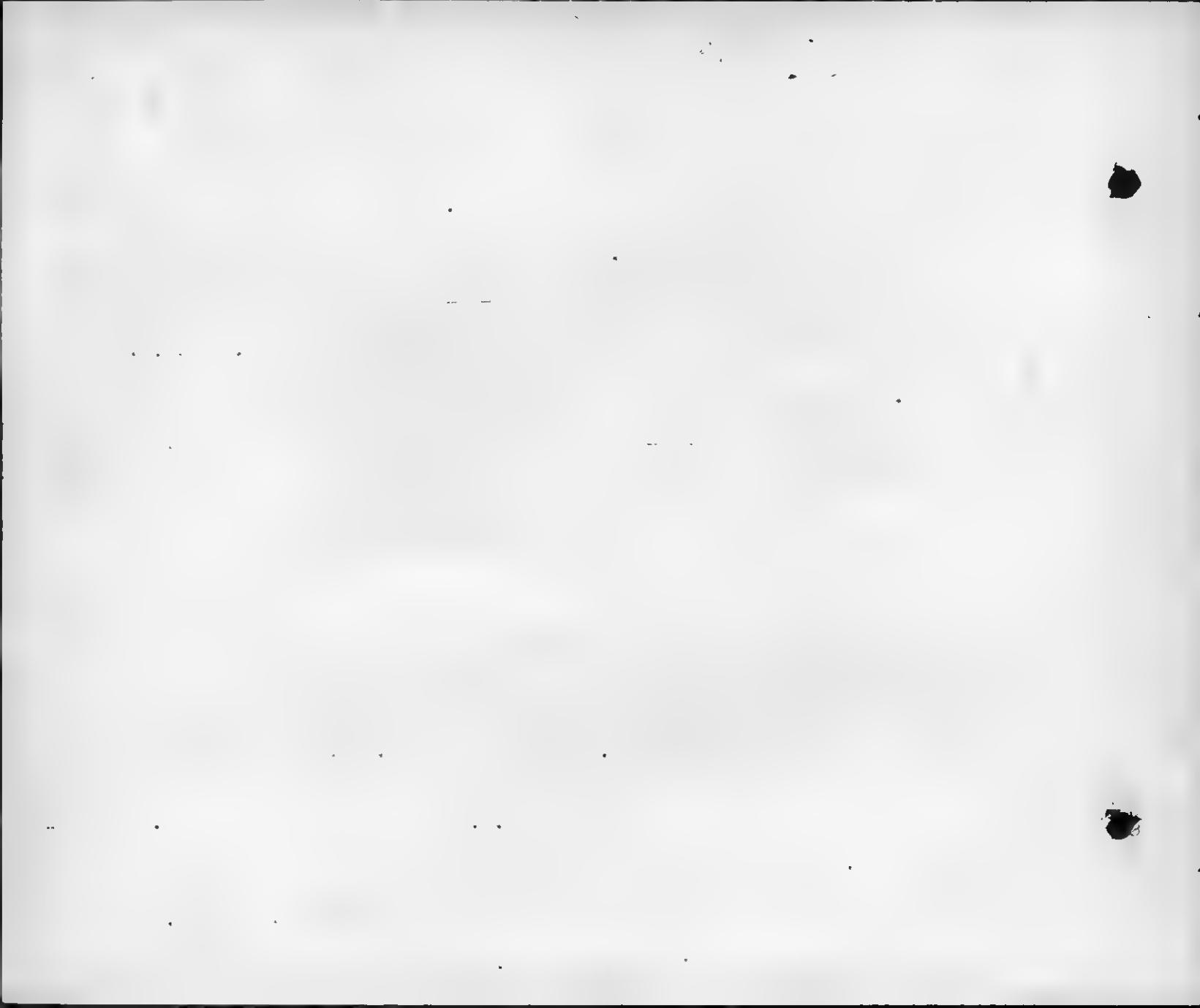
13616

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-troussil permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Virginia		b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2719 S. Wayne Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle A.	Last JAMES	4. DATE OF DEATH December	Month 26	Day Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-15-01	9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Wachapreague, Virginia.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Alford G. James		14. MOTHER'S MAIDEN NAME Georgie Nock					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 040-14-2834		17. INFORMANT Hospital Records, VAH, Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease, severe</i>						INTERVAL BETWEEN ONSET AND DEATH Unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerosis, generalized, severe</i>		DUE TO (b)				Unknown	
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 10, 1958, to Dec. 26, 1958, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Joseph C. Grasberger M.D. V.A. Hospital, Perry Point, Md. 12-27-58							
PHYSICIAN'S NAME (Type) J. C. Grasberger, M.D. Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/30/58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE R. L. Thompson		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE JAN 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



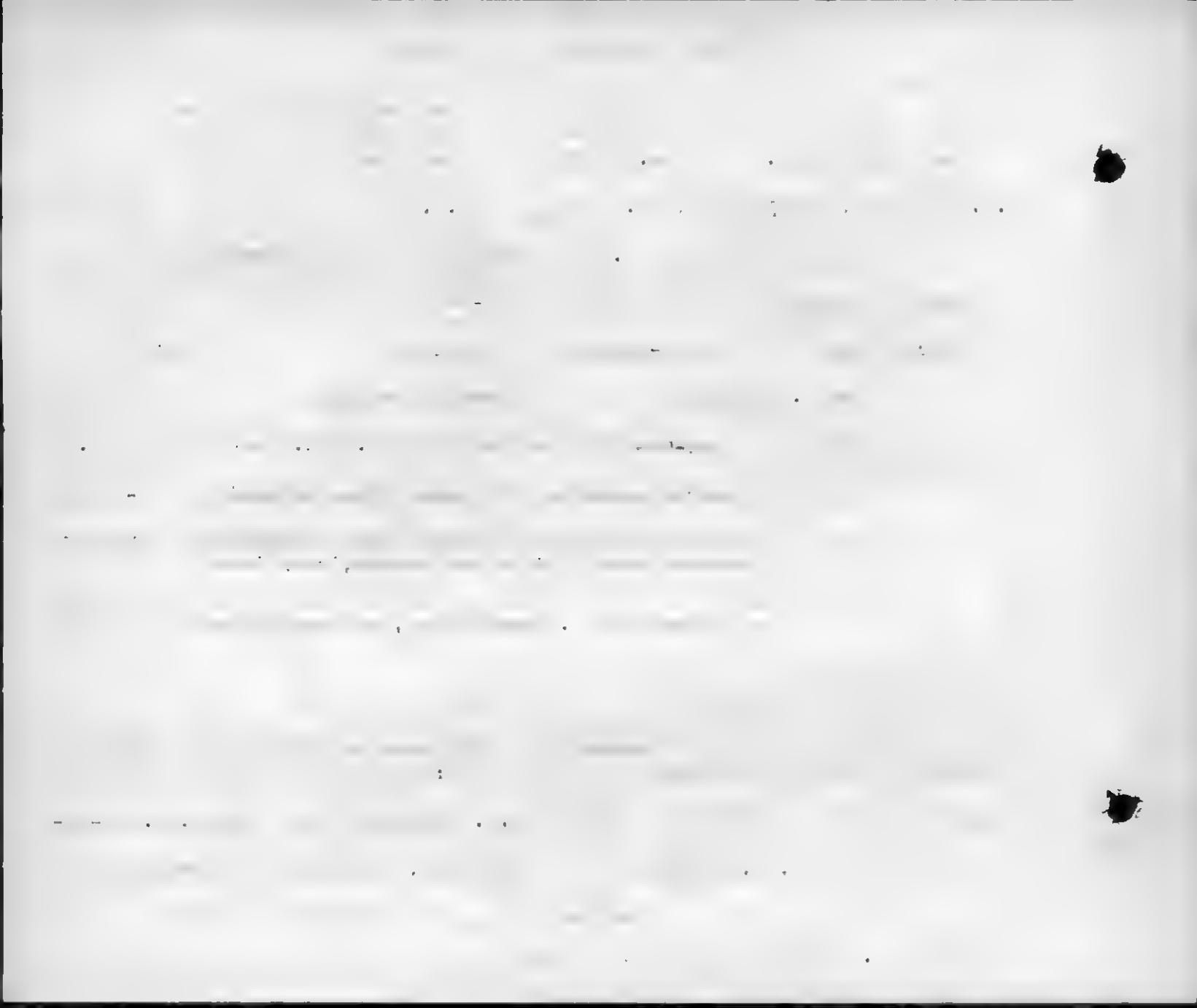
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13617

13636 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN b. 1 mo. 26 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V.A. Hospital, Perry Point, Md.		e. IS RESIDENCE ON A FARM? unknown				
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle A.	Last JOHNSON			
4. DATE OF DEATH	Month December	Day 17	Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-01			
9. AGE (in years lost birthday) 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician	11. KIND OF BUSINESS OR INDUSTRY Self-employed	12. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME John F. Johnson	14. MOTHER'S MAIDEN NAME Dora Mae Anthony					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes	16. SOCIAL SECURITY NO. 222-03-8773	17. INFORMANT Hospital Records, VAH, Perry Point, Md.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia left lower lobes unresolved INTERVAL BETWEEN ONSET AND DEATH 3-4 days DUE TO 526X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema bullous bilateral upper lobes and bronchiectasis bilateral severe, lower lobes unknown DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized, moderately severe						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VA	(County)	(State)
21. I certify that I attended the deceased from October 21, 1958 , to December 17, 1958 , and that death occurred 11:40 a.m. from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>S. P. Lacerva</i>	ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md.			DATE SIGNED 12-17-58		
PHYSICIAN'S NAME (Type) S. P. LACERVA	Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/19/1958	22c. NAME OF CEMETERY OR CREMATORIUM Bayview Methodist	22d. LOCATION (City, town, or county) (State) Bayview, Maryland			
23. FUNERAL DIRECTOR SIGNATURE <i>Joseph R. Grant</i>	ADDRESS Northeast, Maryland	24a. REC'D BY REGISTRAR DEC 22 '58	24b. REGISTRAR'S SIGNATURE C. C. - 8 - 10-12			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Conowingo</i>	c. LENGTH OF STAY IN 1b <i>Lifetime</i>	b. COUNTY <i>Cecil</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Conowingo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Mt. Gorah Road</i>	e. STREET ADDRESS <i>Mt. Gorah Road</i>	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Vernon</i>	First <i>Vernon</i>	Middle <i>S.</i>	Last <i>Jones</i>	
4. DATE OF DEATH <i>12 7 1958</i>	Month <i>12</i>	Day <i>7</i>	Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 25, 1892</i>	
9. AGE (In years lost birthday) <i>66 yrs</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>X</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i>	10c. BIRTHPLACE (State or foreign country) <i>Conowingo, Md.</i>	
11. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		12. MOTHER'S MAIDEN NAME <i>Jessie Bradford</i>		
13. FATHER'S NAME <i>William James Jones</i>	14. Address <i>Mrs. Virgin Henry - Slave de Grace, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>216-20-7940</i>	17. INFORMANT <i>Mrs. Virgin Henry - Slave de Grace, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>Arteriosclerotic heart disease</i> (b) DUE TO <i>Cardiac decompression</i> (c) DUE TO <i>one wk.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rising Sun, Md.</i>	20f. (City or town) <i>Rising Sun, Md.</i>	(County) <i>Rising Sun, Md.</i>
21. I certify that I attended the deceased from <i>6/1/1958</i> to <i>12/7/1958</i> , that I last saw the deceased alive on <i>12/6/1958</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Neil Taylor Jr.</i>				
ADDRESS (Street, city or town, state) <i>Rising Sun, Md.</i> DATE SIGNED <i>12/9/58</i>				
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-10-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Gorah Cemetery</i>	22d. LOCATION (City, town, or county) <i>Conowingo, Md.</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hebe J. Bullock - Slave de Grace, Md.</i>		24a. ADDRESS <i>1118 8th Street, Rising Sun, Md.</i>	24b. REC'D BY REGISTRAR <i>DEC 15 1958</i>	24c. REGISTRAR'S SIGNATURE <i>Hebe J. Bullock</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

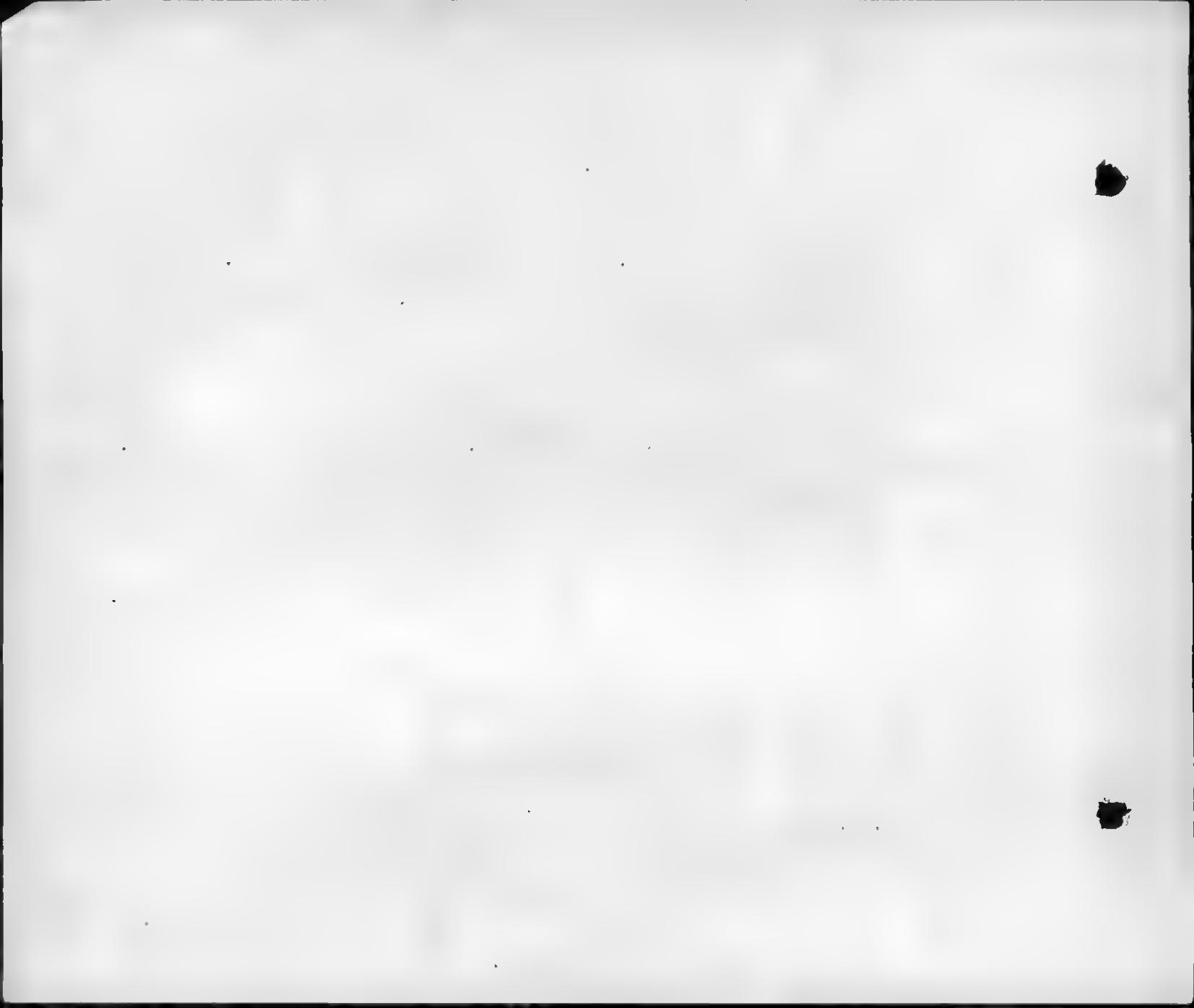
13613
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13638 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Reg. Dist. No

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, RFD		c. LENGTH OF STAY IN lb 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, RFD		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Eugene	Middle O.	Last Keith	4. DATE OF DEATH Dec. 16	Month Year 1958	Day Year
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1891	9. AGE (In years last birthday) 67 yrs.	10. UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) South Caroline		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Keith				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown)		16. SOCIAL SECURITY NO. 156-05-2310		17. INFORMANT Geneva H. Keith, Port Deposit, RFD, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause first. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R. C. Dodson</i>	EXAMINER'S NAME (Type) <i>Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	12/17/58	DATE SIGNED
22a. BURIAL / CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 12/20/58	22c. NAME OF CEMETERY OR CREMATORIUM Cokesbury Cemetery	22d. LOCATION (City, town, or county) Port Deposit RFD, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. C. Kilkenny & Son</i>	ADDRESS Perryville, Md.	24a. REC'D BY REGISTRAR DATE DEC 20 1958	24b. REGISTRAR'S SIGNATURE <i>C. W. J. Kilkenny</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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13618 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 34 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Childs				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union				e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Caroline	Middle A	Last Kirkpatrick	4. DATE OF DEATH Jan 10 1876	Month 12	Day 5	Year 19 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10 1876	9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Deirling		14. MOTHER'S MAIDEN NAME Mary Gatten						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Margaret Has on		Address Childs, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		Carcinoma of the colon				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 21 56		20f. (City or town) (County) (State) Dec. 5, 19 58		
21. I certify that I attended the deceased from alive on Dec 5, 19 58				21. I certify that I last saw the deceased alive on Dec 5, 19 58, and that death occurred at 2:50 p.m. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 12/5/58		
ACTUAL SURVIVING TIME <i>Ralph Andrews Jr. M.D.</i>				M.D.				
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr. M.D.				Elkton, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-1958		22c. NAME OF CEMETERY OR CREMATORIUM North East Methodist		22d. LOCATION (City, town, or county) (State) North East, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR REC 11 '58		24b. REGISTRAR'S SIGNATURE <i>John L. Thorne</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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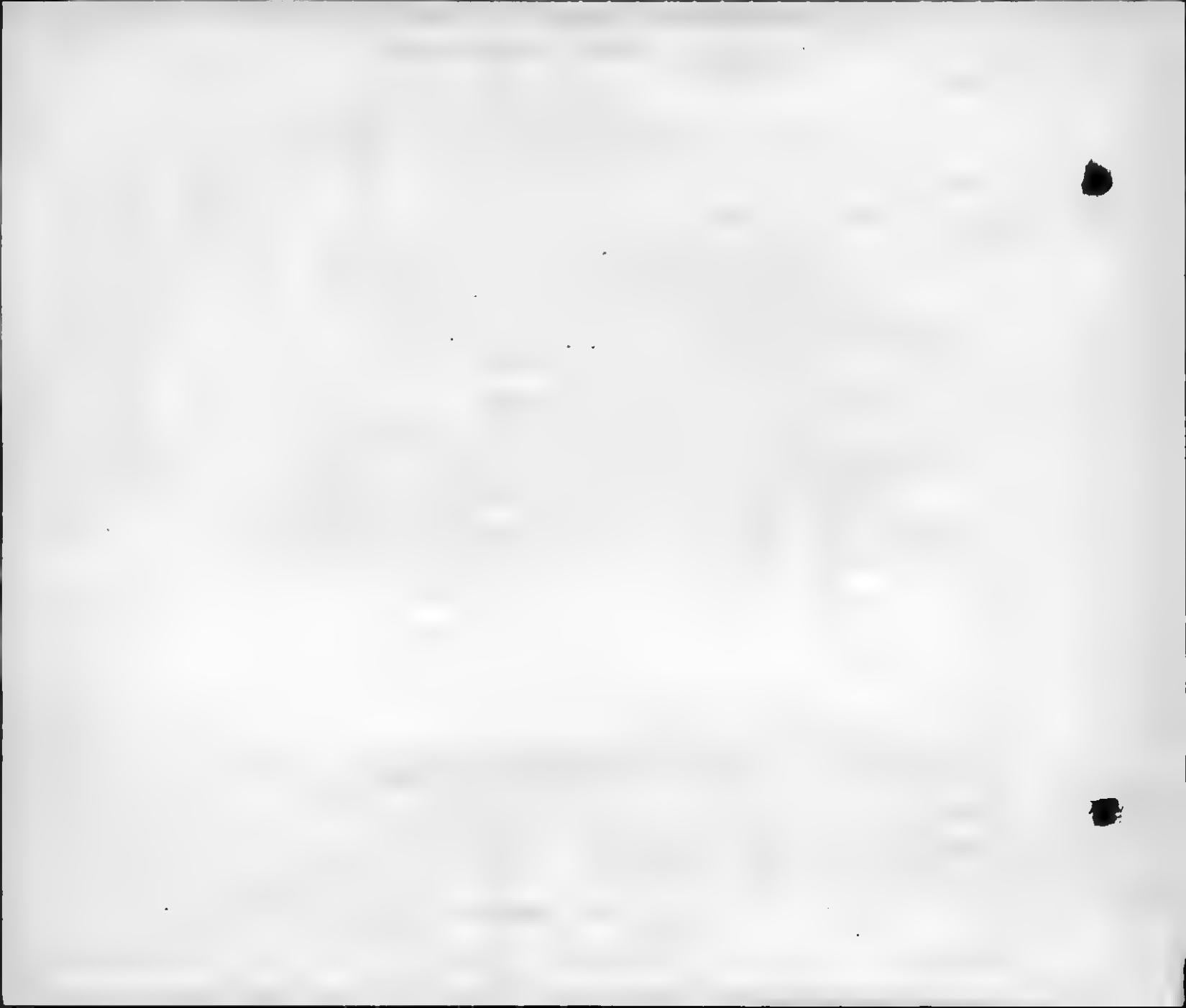
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN lb 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Walter	Middle P.	Last Lewis	4. DATE OF DEATH Month 12 Day 9 Year 58		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1880	9. AGE (In years from birthday) yrs. 78	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman Retired 10 yrs		10b. KIND OF BUSINESS OR INDUSTRY Penns R.R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Lewis		14. MOTHER'S MAIDEN NAME Sabina Harris					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 717-07-5362		17. INFORMANT Mrs Georgiana Lewis North East, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 10 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		YEARS			
(c) GENERALIZED ARTERIO SCLEROSIS		YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>Nov. 20, 1958</u> , to <u>12-9-58</u> , that I last saw the deceased alive on <u>Dec. 1, 1958</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Luis M. Cuza</u> PHYSICIAN'S NAME (Type) <u>Luis M. Cuza</u>		M.D.		ADDRESS (Street, city or town, state) <u>NORTH EAST, Md.</u>		DATE SIGNED <u>Dec. 12-9-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-14-1958	22c. NAME OF CEMETERY OR CREMATORIUM Principio Methodist	22d. LOCATION (City, town, or county) Principio, Cecil Co., Md	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph O'Grady</u>		ADDRESS North East, Maryland	24a. REC'D BY REGISTRAR DAT DEC 12 '58	24b. REGISTRAR'S SIGNATURE <u>Carroll S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 80 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Olive	Middle Shallcross	Last Lowe	4. DATE OF DEATH	Month 12	Day 2	Year 1958
5. SEX Fem ale	6. COLOR OR RACE Whi white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 15 1891	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY =		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hiram W Shallcross		14. MOTHER'S MAIDEN NAME Anna Abbott					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Beasie M Baileff		Address North East (Rural)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic Coma DUE TO (c) Diabetes.							
INTERVAL BETWEEN ONSET AND DEATH 3 0 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetic Gangrene							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) A amputation of left foreleg Nov 18/58							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North East, Maryland		(County) (State)	
21. I certify that I attended the deceased from Sep 13, 1958 , to Dec 2, 1958 , that I last saw the deceased alive on Dec 2, 1958 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. Arthur Cantwell		M.D.		ADDRESS (Street, city or town, state) North East, Maryland		DATE SIGNED Dec 3/58	
PHYSICIAN'S NAME (Type) H. Arthur Cantwell M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 6, 1958		22c. NAME OF CEMETERY OR CREMATORIUM North East Methodist		22d. LOCATION (City, town, or county) North East (Cecil Co) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DEC 4 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13623

13620 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b 77 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D. #3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry	Middle Armstrong	Last Lungren
4. DATE OF DEATH	Dec 10	Month	Day 1958 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1880
9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Lungren		14. MOTHER'S MAIDEN NAME Martha Ferguson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO -----	
17. INFORMANT Mrs. Minnie Kerr Lungren, R. D. 3, Elkton		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Sudden Paroxysmal Arteric sclerosis 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1958, to Dec 10, 1958, that I last saw the deceased alive and died on Dec 10, 1958, and that death occurred at (2 hrs). From the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE F. B. Robinson		DATE SIGNED Dec 10, 1958	
PHYSICIAN'S NAME (Type) F. B. Robinson		MD Dr. Ford Pearce	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		22d. LOCATION (City, town, or county) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hickey		24a. REC'D BY REGISTRAR DEC 16 '58	
ADDRESS Elkton, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13624
Reg. Dist. No.

DIRECTOR'S SIGNATURE: *Joseph R. Frank*

1. PLACE OF DEATH a. COUNTY Cecil	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	b. COUNTY Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.	c. LENGTH OF STAY IN lb All life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.	d. STREET ADDRESS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) William	First William	Middle J.	Last McCall
4. DATE OF DEATH 12-21-1958	Month Dec	Day 21	Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lewis G. McCall	14. MOTHER'S MAIDEN NAME Carrie Clark	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or enrollment) No	16. SOCIAL SECURITY NO 218-07-8964	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Sclerosis DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20c. TIME OF INJURY Hour e. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R.C. Dedson</i>	M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-29-58
EXAMINER'S NAME (Type) R.C. Dedson	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 12-21-58	22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cemetery	22d. LOCATION (City, town, or county) (State) North East, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Frank</i>	ADDRESS North East, Md.	24a. REC'D BY REGISTRAR DEC 22 '58	24b. REGISTRAR'S SIGNATURE J. R. Frank

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*W*hen the first *U.S. News & World Report* was published in 1925, it was a modest monthly magazine.

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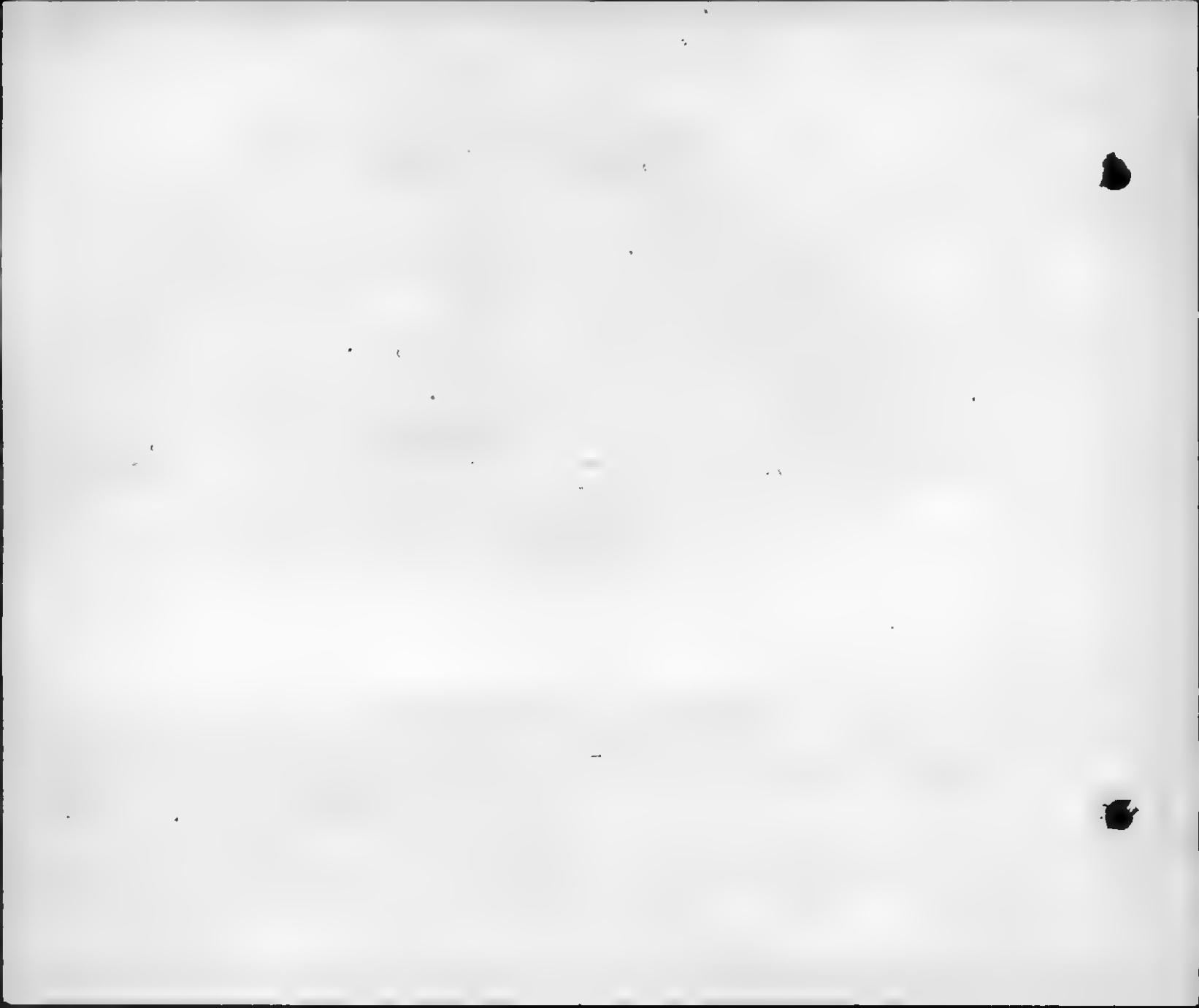
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

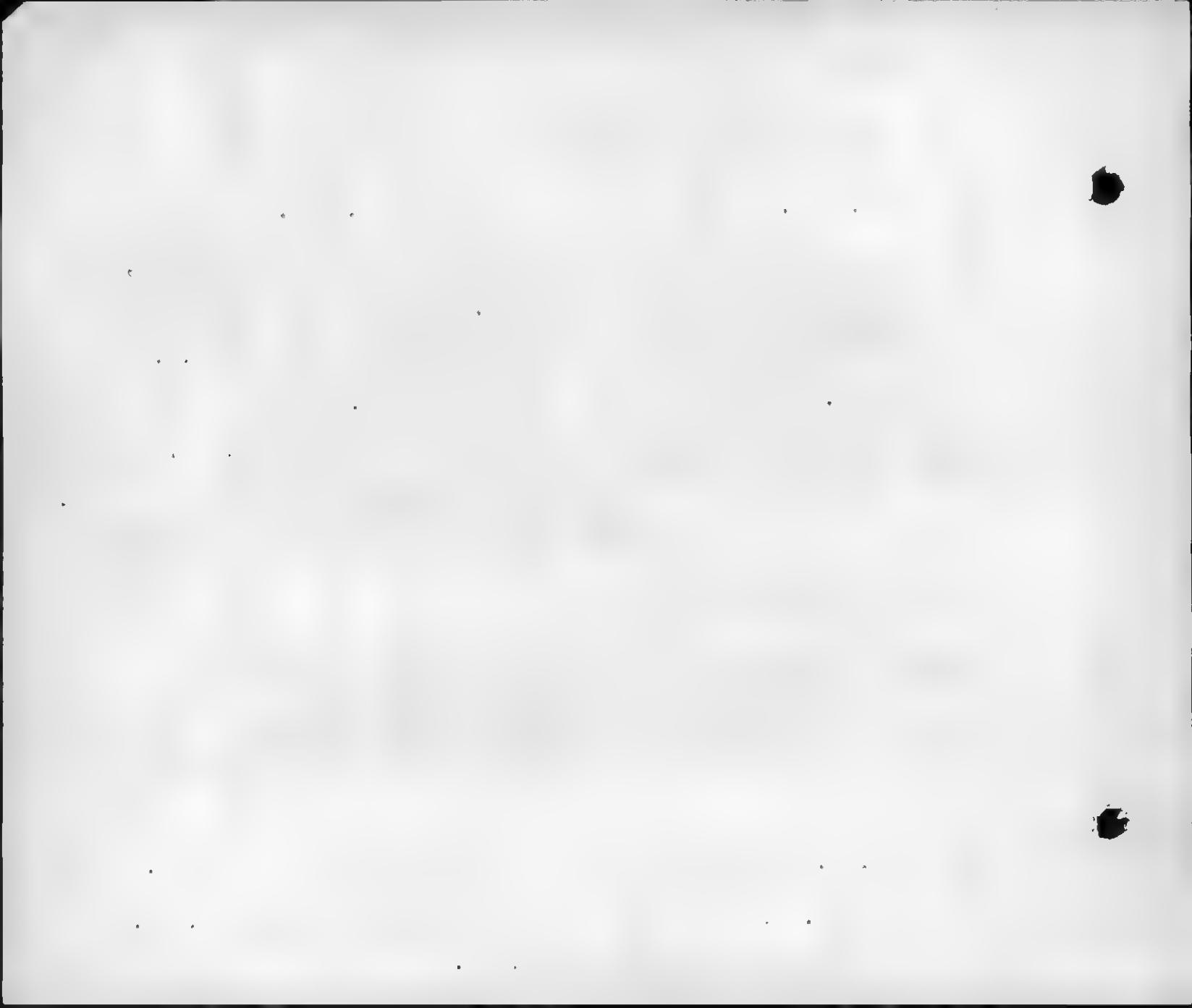
13625

13641 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWNS (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 3Yrs, 4Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		2vo14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2823 Overland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle P.	Last MC GUIRE	4. DATE OF DEATH	Month 12	Day 21	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-91	9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Industry		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME J. MATTHEW MC GUIRE		(D)		14. MOTHER'S MAIDEN NAME MARY A. MANGAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) YES		16. SOCIAL SECURITY NO. 216 22 4717		17. INFORMANT HOSPITAL RECORDS, VAH, PERRY POINT, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia							
4460X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis							
DUE TO (c) Arteriosclerosis, general							
INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition and chronic involutional psychotic reaction							
9 months							
1 year							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-29 , 19 55 , to 12-21 , 19 58 , and death occurred at 3:40A.M.		ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.					
ACTUAL SIGNATURE <i>R. Burke Suitt</i>		DATE SIGNED 12-21-58					
PHYSICIAN'S NAME (Type) R. Burke Suitt, M.D. Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/58		22c. NAME OF CEMETERY OR CREMATORIUM Cathedral		22d. LOCATION (City, town, or county) 430000 & 3rd Street Rd	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. J. Fahey 1318 Sept 18 Bald Head</i>		ADDRESS 1318 S. 18th St. Bald Head		24a. REC'D BY REGISTRAR DATE DEC 24 '58		24b. REGISTRAR'S SIGNATURE C. L. Thomas	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13627

13622 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hosp.</i>		d. STREET ADDRESS <i>Union, Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Richard</i>	Middle <i>Evan</i>	Last. <i>Milburn</i>	4. DATE OF DEATH Month <i>Dec.</i> Day <i>20</i> Year <i>1958</i>	Month <i>Dec.</i> Day <i>20</i> Year <i>1958</i>	Month <i>Dec.</i> Day <i>3</i> Year <i>22</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 20 1858</i>	9. AGE (In years lost birthday) yrs. <i>60</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min. <i>3 22</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Trimble Milburn</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Helen Mackie</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>NONE</i>		17. INFORMANT <i>JOHN T. MILBURN</i>		Address <i>Elkton, Md. Rd #4</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Premature</i> 7/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>		Premature rupture of membrane 7 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Intrauterine infection &/or Healing Membrane</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Newark, Delaware</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 20, 1958</i> to <i>Dec 20, 1958</i> that I last saw the deceased alive on <i>Dec 20, 1958</i> , and that death occurred at <i>4:00 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Newark, Del.</i>		DATE SIGNED <i>Dec 20, 1958</i>	
ACTUAL SIGNATURE <i>Wallace Obenshain</i>		PHYSICIAN'S NAME (Type) <i>WALLACE OBENSHAIN</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>DEC. 23, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>HEAD OF CHRISTIANA</i>		22d. LOCATION (City, town, or county) (State) <i>NEWARK, DELAWARE</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R.T. Jones</i>		ADDRESS <i>Newark, Del.</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 29 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Clint S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

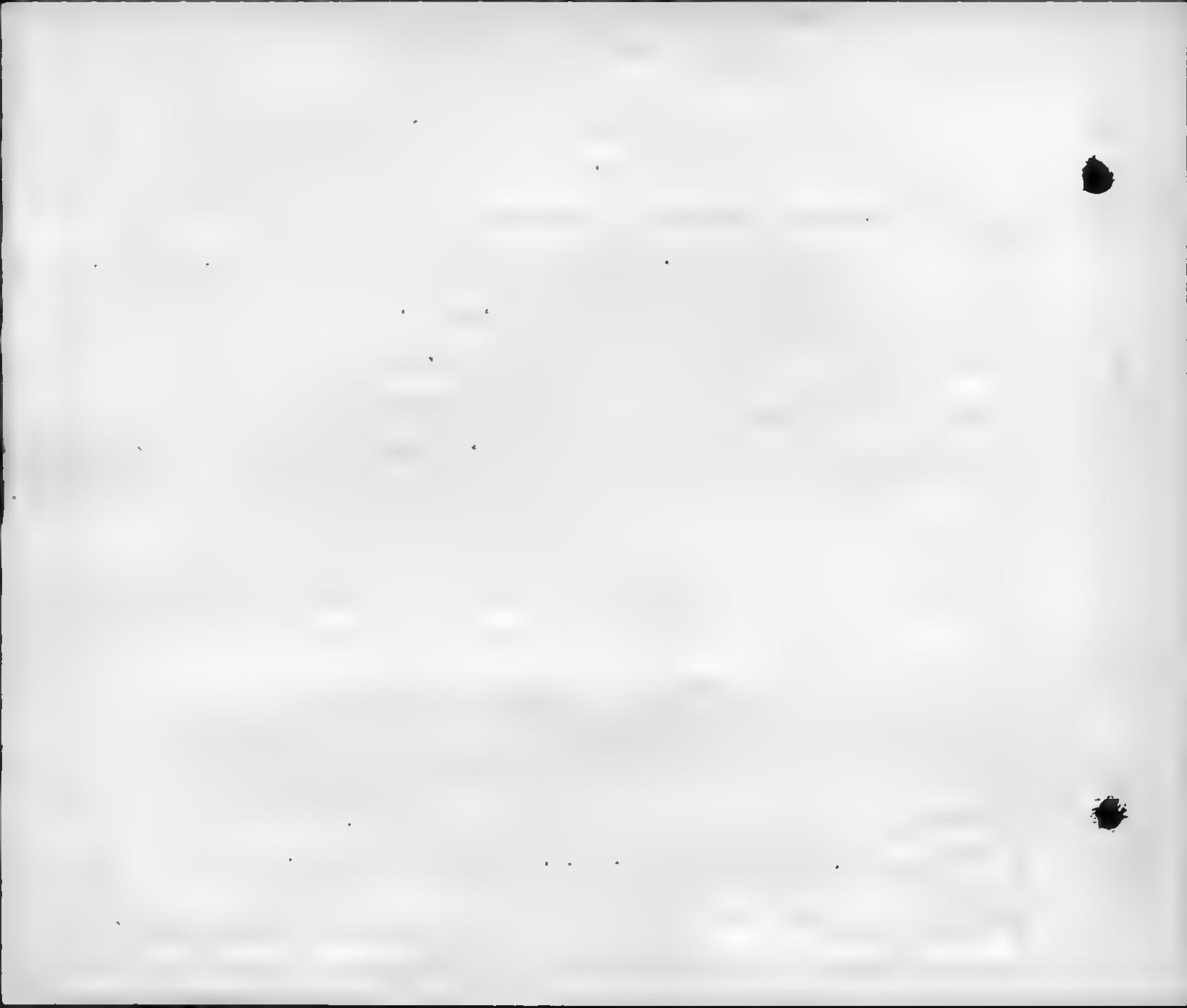
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13628			
Item 2 Film G 237 1-7-59 et													
13623 CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.					b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 3 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			d. STREET ADDRESS 102 Church St. (Sister's home)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home													
3. NAME OF DECEASED (Type or print)		First Charlatte J. Plummer		Middle	Lost	4. DATE OF DEATH Dec. 13th 1958	Month	Day	Year				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13th 1870	9. AGE (in years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeping					10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Md.					12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Mark Manlove					14. MOTHER'S MAIDEN NAME Ella Conlin								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Lulu P. Brustle 6445 Market St., Upper Darby Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO lying cause (c).										INTERVAL BETWEEN ONSET AND DEATH unknown Pa.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe generalized arthritis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that I attended the deceased from 7/18/53, 19, to 12/13/1958, that I last saw the deceased alive on 12/13/1958, and that death occurred at 8:13 p.m., from the causes and on the date stated above. ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D. PHYSICIAN'S NAME (Type)										ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 12/14/58 Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/58		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery			22d. LOCATION (City, town, or county) Cheapeake City Md.			(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Lester Daniels Miss Luton Del.					ADDRESS		24a. REC'D BY REGISTRAR DEC 17 1958			24b. REGISTRAR'S SIGNATURE Lester Daniels			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 21 237 1-9-59 et

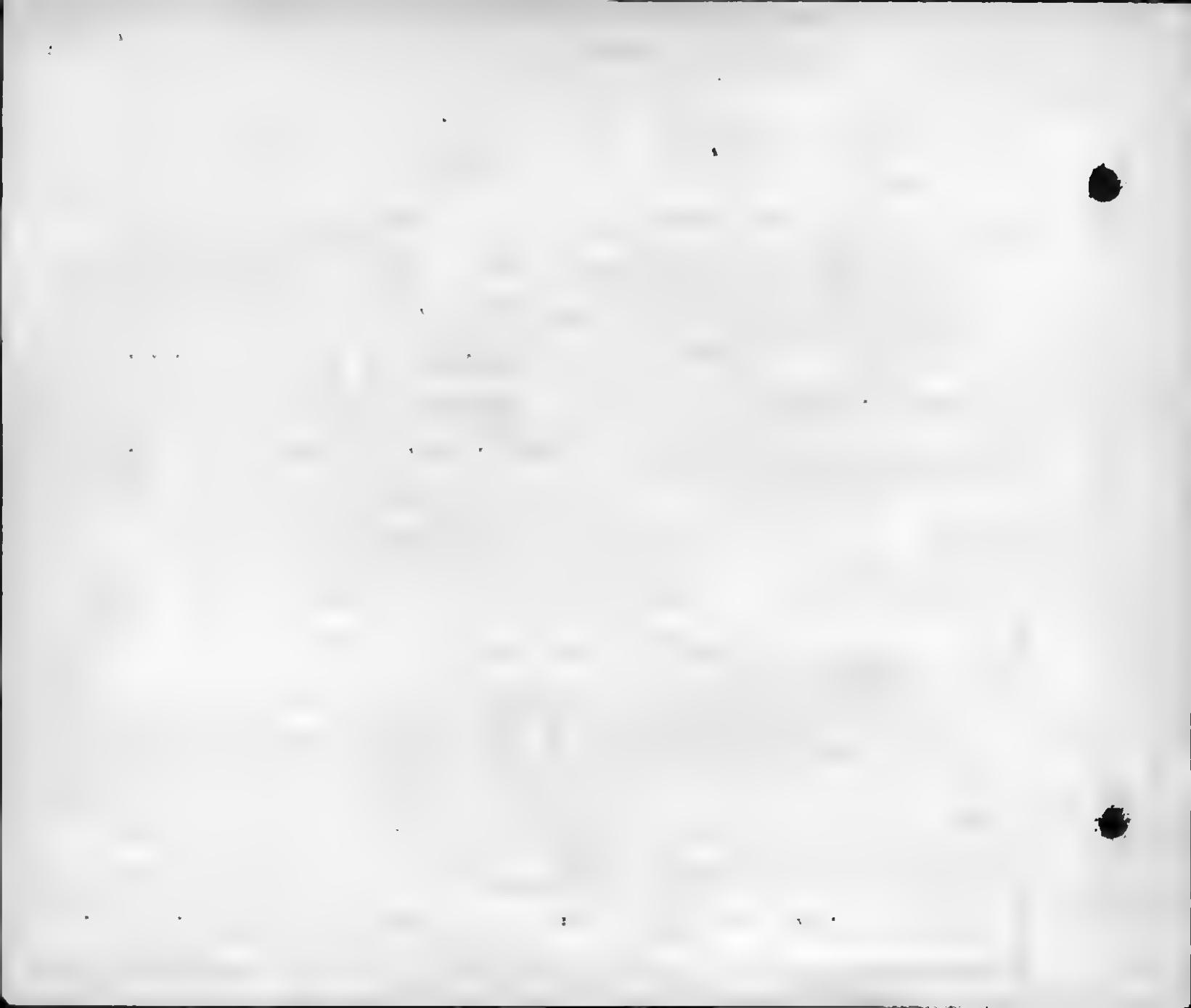
13623

13624

CERTIFICATE OF DEATH

Reg. Dist. No.

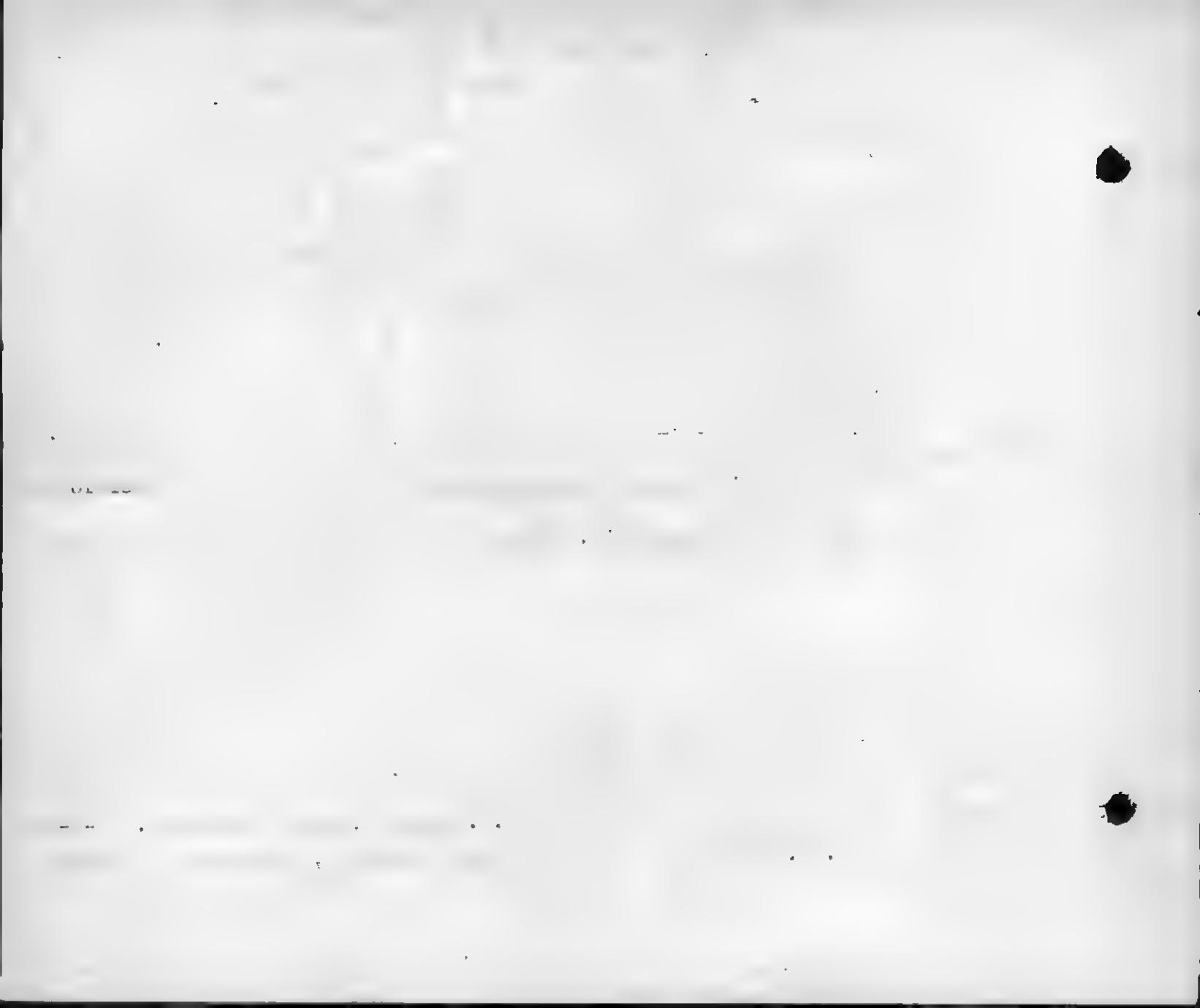
1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				b. COUNTY Cecil						
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Earleville						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Private home"				d. STREET ADDRESS						
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First SUSIE	Middle ELLA	Last PRICE	4. DATE OF DEATH December 26 1958	Month December	Day 26	Year 1958		
5. SEX		6. COLOR OR RACE Female White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 11, 1899	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles H. Bailey				14. MOTHER'S MAIDEN NAME Emma See						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James H. Price,		Address Earleville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma of sigmoid DUE TO (c) 2 years.										INTERVAL BETWEEN ONSET AND DEATH 20 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Earleville		(County) Cecil Co.	(State) Md.	
21. I certify that I attended the deceased from Sept 1958 to 26 Dec 1958 , that I last saw the deceased alive on 26 Dec 1958 , and that death occurred at 7 a.m. from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) Earleville, Md.										
DATE SIGNED 27 Dec 58										
ACTUAL SIGNATURE Wallace Obenshain		M.D.								
PHYSICIAN'S NAME (Type) WALLACE OBENSHAIN		Cecilton, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 28, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Galena Cem.		22d. LOCATION (City, town, or county) Galena, Kent Co.		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		ADDRESS Wellesington, Md.		24a. REC'D BY REGISTRAR DATE DEC 30 '58		24b. REGISTRAR'S SIGNATURE On 118 times				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13642 CERTIFICATE OF DEATH

Reg. Dist. No.
 13650
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1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 8 yrs 8 mos 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia		b. COUNTY Norfolk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk		d. STREET ADDRESS 5839 - 6th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First OTIS	Middle ODELL	Last SAUNDERS	4. DATE OF DEATH December 31, 1958	Month December	Day 31	Year 58		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 9, 1923	9. AGE (In years (last birthday) 35 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY USA.			
13. FATHER'S NAME B. E. SAUNDERS				14. MOTHER'S MAIDEN NAME Minnie Irene Twine					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II 245-16-3493		17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bilateral bronchopneumonia								INTERVAL BETWEEN ONSET AND DEATH Over 10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Tuberculosis, active				unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 28, 1958 , to December 31, 1958 , and that death occurred at 2:35 P.M. , from the causes and on the date stated above.								ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <i>W. M. Harris</i>		M.D. V.A. Hospital, Perry Point, Md. 1-2-59							
PHYSICIAN'S NAME (Type) W. M. HARRIS		Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/5/1959		22c. NAME OF CEMETERY OR CREMATORIUM Hampton National		22d. LOCATION (City, town, or county) Hampton, Virginia.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>		ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DATE JAN 7 1959		24b. REGISTRAR'S SIGNATURE <i>John S. Knapp</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13631

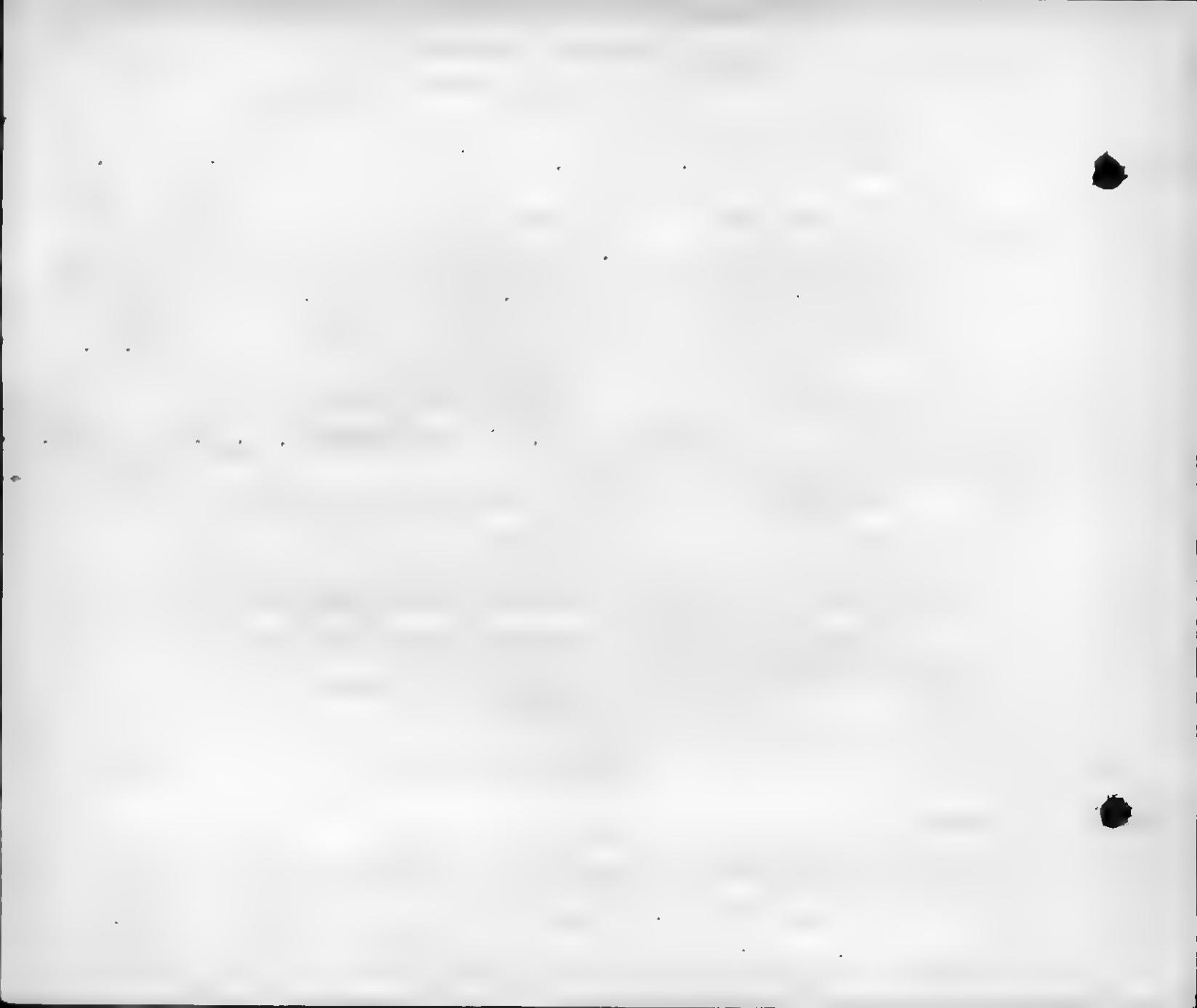
13643 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Newark R.D.2 Del.		c. LENGTH OF STAY IN lb 69 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural, Newark R. D. 2, Del.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Lillie		First	Middle J.	Last Scott	4. DATE OF DEATH December 9 1958	Month	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Apr. 23, 1889	9 AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Wesley Price		14. MOTHER'S MAIDEN NAME Katharine Holland					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lillie Peterson, R. D. 2, Newark, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>arteriosclerotic heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 10, 1958</u> , to <u>Dec. 9, 1958</u> , that I last saw the deceased alive on <u>Dec. 9, 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 17-12-58	
ACTUAL SIGNATURE <i>E. Hughes Nutter</i>		M.D.		<u>106 Main St.</u>			
PHYSICIAN'S NAME (Type) E. HUGHES NUTTER				Newark, Del.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery		22d. LOCATION (City, town, or county) Cecil County, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i>		ADDRESS Elkton, Maryland		24a. REC'D BY REGISTRAR DATE DEC 16 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13632

13625

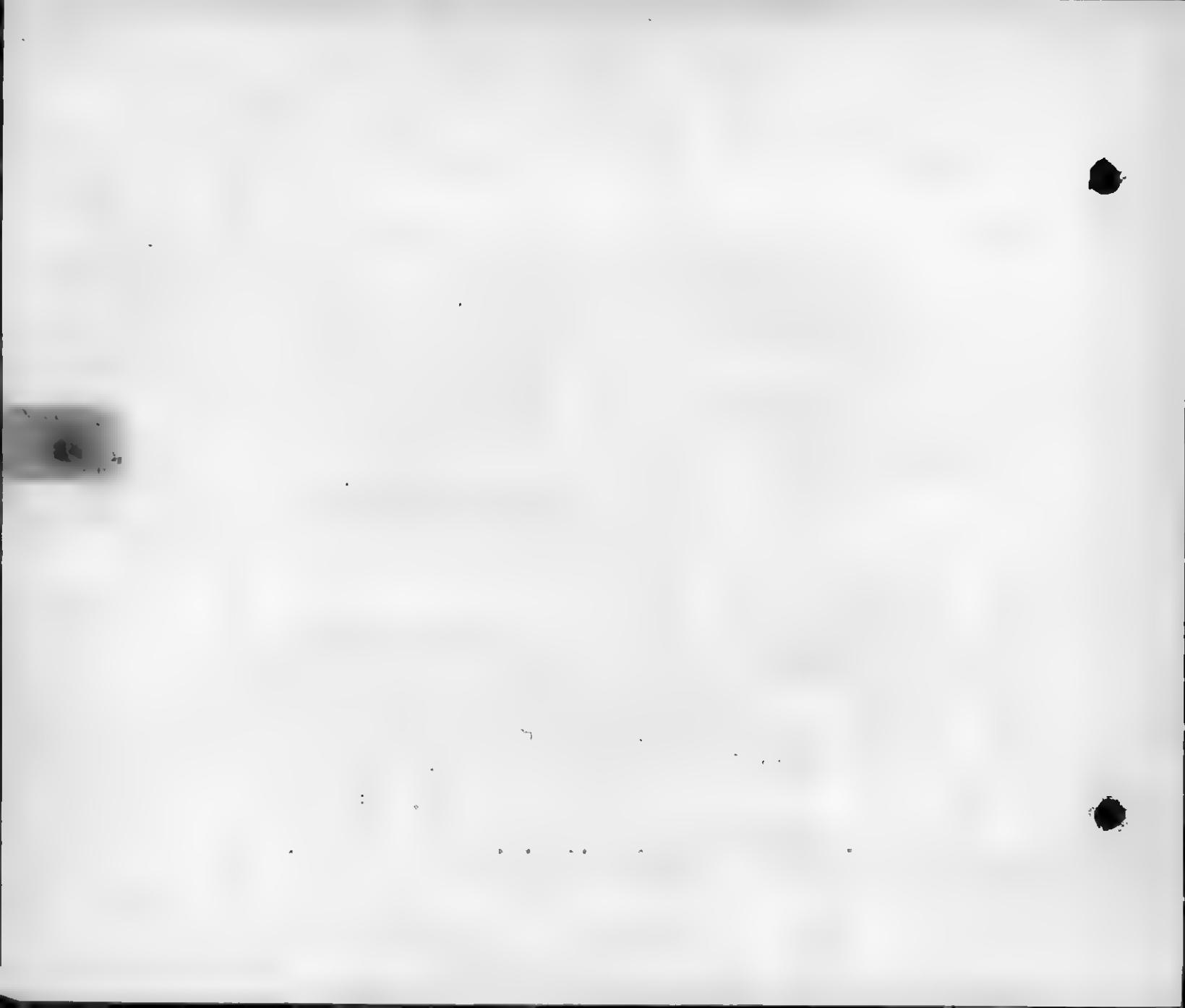
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON</i>		c. LENGTH OF STAY IN lb <i>5 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3 MANOR Rd.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>	
3. NAME OF DECEASED (Type or print) <i>Robena</i>		First <i>Clara</i>	Middle <i>Spencer</i>
4. DATE OF DEATH <i>DEC. 8 1958</i>		Last <i>SPENCER</i>	Month <i>Dec.</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 2, 1872</i>
9. AGE (In years last birthday) <i>86 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House Wife</i>	11. BIRTHPLACE (State or foreign country) <i>Va.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thomas</i>	
14. MOTHER'S MAIDEN NAME <i>Clara Emline</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Denton Williams, Elkton</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypertensive arteriosclerotic</i> DUE TO <i>cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>	
Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 5, 1956</u> , to <u>December 8, 1958</u> , that I last saw the deceased alive on <u>December 6, 1958</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>233 E. Main Street</i>	
ACTUAL SIGNATURE <i>Ralph Andrews Jr.</i>		DATE SIGNED <i>12/8/58</i>	
PHYSICIAN'S NAME (Type) <i>S. Ralph Andrews, Jr., M.D.</i>		ELKTON, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/12/58</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Woodlawn Cemetery</i>		22d. LOCATION (City, town, or county) <i>Merser County WVA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Walter de Boe Jr.</i>		ADDRESS <i>Elkton, Md.</i>	
24a. REC'D BY REGISTRAR <i>DEC 12 1958</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Knapp</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13633

13644

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Cecil</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON Rural</i>		c. LENGTH OF STAY IN lb <i>25 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural ELKTON</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ELKTON Rural</i>		d. STREET ADDRESS <i>1 Rd # 3</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>William</i>		First	Middle	Lost	4. DATE OF DEATH <i>Startt</i>	Month <i>Dec.</i>	Day <i>6</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 4 1882</i>	9. AGE (In years lost birthday) yrs. <i>76</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>El. SA</i>		
13. FATHER'S NAME <i>James Startt</i>		14. MOTHER'S MAIDEN NAME <i>Verma Lane</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>216-10-3295</i>		17. INFORMANT <i>Mary Startt, ELKTON</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Prostate</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1955-58</i>		
177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO								
(c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Dec. 6 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Elkton, Md.</i>		20f. (City or town) <i>Elkton</i>		(County) <i>Carroll</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>1955</i> to <i>Dec. 6, 1958</i> , that I last saw the deceased alive on <i>Dec. 6, 1958</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Elkton, Md.</i> DATE SIGNED <i>Dec. 6, 1958</i>		
ACTUAL SIGNATURE <i>Donald H. Sprecher</i>								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/9/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>ELKTON Cem.</i>		22d. LOCATION (City, town, or county) <i>ELKTON</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>He Walter de Rose, Jr.</i>		ADDRESS <i>Elkton, Md.</i>		24a. REC'D BY REGISTRAR <i>DEC 11 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. F. ...</i>		



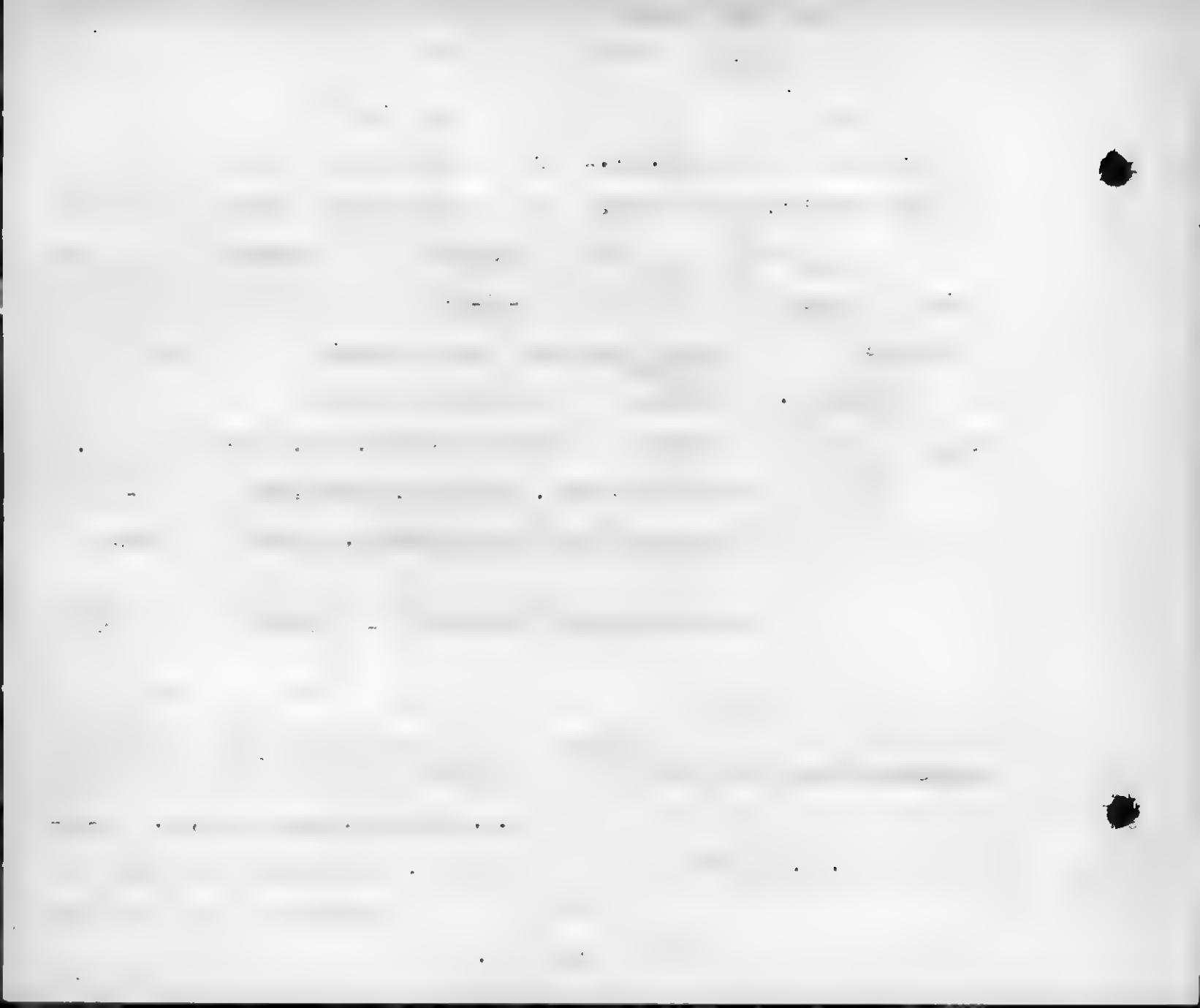
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13634

13645 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] b. STATE West Virginia		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 30 yrs. 5 mo. 19 days		d. STREET ADDRESS Clarksburg		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> unknown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 504 Monticello Avenue							
3. NAME OF DECEASED (Type or print)	First HARRY	Middle (NMI)	Last STROTHER	4. DATE OF DEATH December 12 1958	Month Day Year						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-88	9. AGE (in years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Consolidated Coal Company		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Charles J. Strother		14. MOTHER'S MAIDEN NAME Nancy Ann Swager									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO 420.0						INTERVAL BETWEEN ONSET AND DEATH 7-10 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic heart disease, severe						unknown					
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X Arteriosclerosis generalized - unknown						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)							
21. I certify that I attended the deceased from June 23, 1928 , to December 12 1958 , and XXXXXX and that death occurred at 9:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>N. R. Strother</i> M.D. V.A. Hospital, Perry Point, Md. 12-12-58						DATE SIGNED					
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services									
22a. BURIAL/CREMAT. ON REMOVAL (Specify) Greenlawn		22b. DATE THEREOF 12/13/58		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn		22d. LOCATION (City, town, or county) Clarksburg, West Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 13 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be joined with
the registrar paper.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

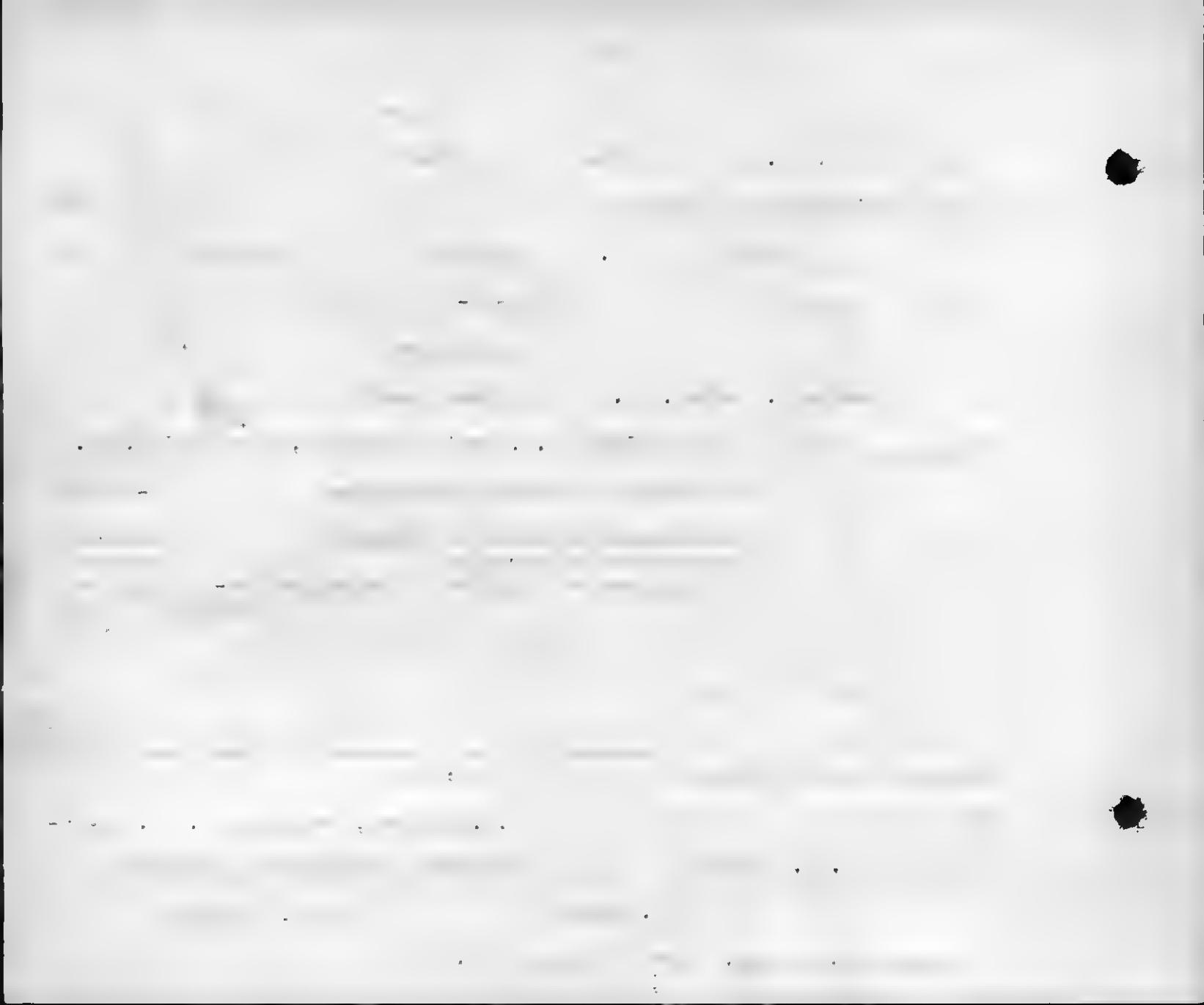
13635

13646

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street		d. STREET ADDRESS 12 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES unknown	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle S.	Last WALTER JR	4. DATE OF DEATH December 14	Month 1958	Day IF UNDER 1 YEAR Months	Year IF UNDER 24 HRS Days Hours Min
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 11-26-21	9. AGE (In years last birthday) 37 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles S. Walter, Sr.		14. MOTHER'S MAIDEN NAME Ethel Knight					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WW II 218 18 1063		17. INFORMANT V.A. Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 5820		DUE TO Peritonitis localized and diffuse		INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Extravasated contents of viscera		DUE TO Abscess of the pancreas		unknown		unknown	
(c) Chronic pancreatitis due to infection Non-specific				unknown		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I VA				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) While at work					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Belair, Maryland		(County)	(State)
21. I certify that I attended the deceased from November 24, 1958, to December 14, 1958, and that death occurred at 9:20 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. P. Lacerva</i>				ADDRESS (Street, city or town, state) MD. V.A. Hospital, Perry Point, Md.		DATE SIGNED 12-15-58	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/17/58	22b. DATE THEREOF 12/17/58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Tabor		22d. LOCATION (City, town, or county) Belair, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Pennington & Son, Havre de Grace, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 18 1958		24b. REGISTRAR'S SIGNATURE <i>J. Trahan</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13636

13647

CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial; cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY HARFORD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. LENGTH OF STAY IN lb 3mths. 12days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JOPPA				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> unknown				
3. NAME OF DECEASED (Type or print) HERBERT		First A.	Middle WILLIAMS	Last WILLIAMS	4. DATE OF DEATH December 7, 1958	Month December	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1891	9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME GEORGE WILLIAMS			14. MOTHER'S MAIDEN NAME ELLEN GIBSON					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO 220-20-7765		17. INFORMANT Hosp. Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO 420.0 INTERVAL BETWEEN ONSET AND DEATH 6-7 days								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO 491.8 UNKNOWN								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) JOPPA		20f. (City or town) (County) (State) JOPPA, MD	
21. I certify that I attended the deceased from Aug. 26, 1958, to Dec. 7, 1958, and that death occurred at 5:00A.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) MD. V.A. Hospital, Perry Point, Md. DATE SIGNED 12-8-58								
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-58		22c. NAME OF CEMETERY OR CREMATORIAL Mountain Cemetery		22d. LOCATION (City, town, or county) (State) JOPPA, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE BULLOCK'S MORTUARY,			ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DEC 15 '58		24b. REGISTRAR'S SIGNATURE C. J. L. Trahan	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1 X
 13648 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 13637
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN TB 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lewis		First	Middle	Last	4. DATE OF DEATH 12 22 1958	Month	Doy	Year	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12-3-1904	9. AGE (in years last birthday) 54 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Owner		10b. KIND OF BUSINESS OR INDUSTRY Garage Repair		11. BIRTHPLACE (State or foreign country) Culpepper, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Collins S Williams		14. MOTHER'S MAIDEN NAME Margarette Sheppard		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215-34-0337		17. INFORMANT Margarette Williams North East, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis with myocadditis Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Hypertension DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>R.C. Dodson</i>		DATE SIGNED 12-23-58							
EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-26-58	22c. NAME OF CEMETERY OR CREMATORIAL Lignum Cey						
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. L. Patterson, Perryville, Md.</i>		ADDRESS	24a. LOCATION (City, town, or county) Culpepper, Va.						
		DATE	24b. REC'D BY REGISTRAR DEC 2 9 '58						
			24c. REGISTRAR'S SIGNATURE <i>O. L. Smith & K. J. Lee</i>						

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“*It is the first time I have ever seen such a thing.*”

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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96

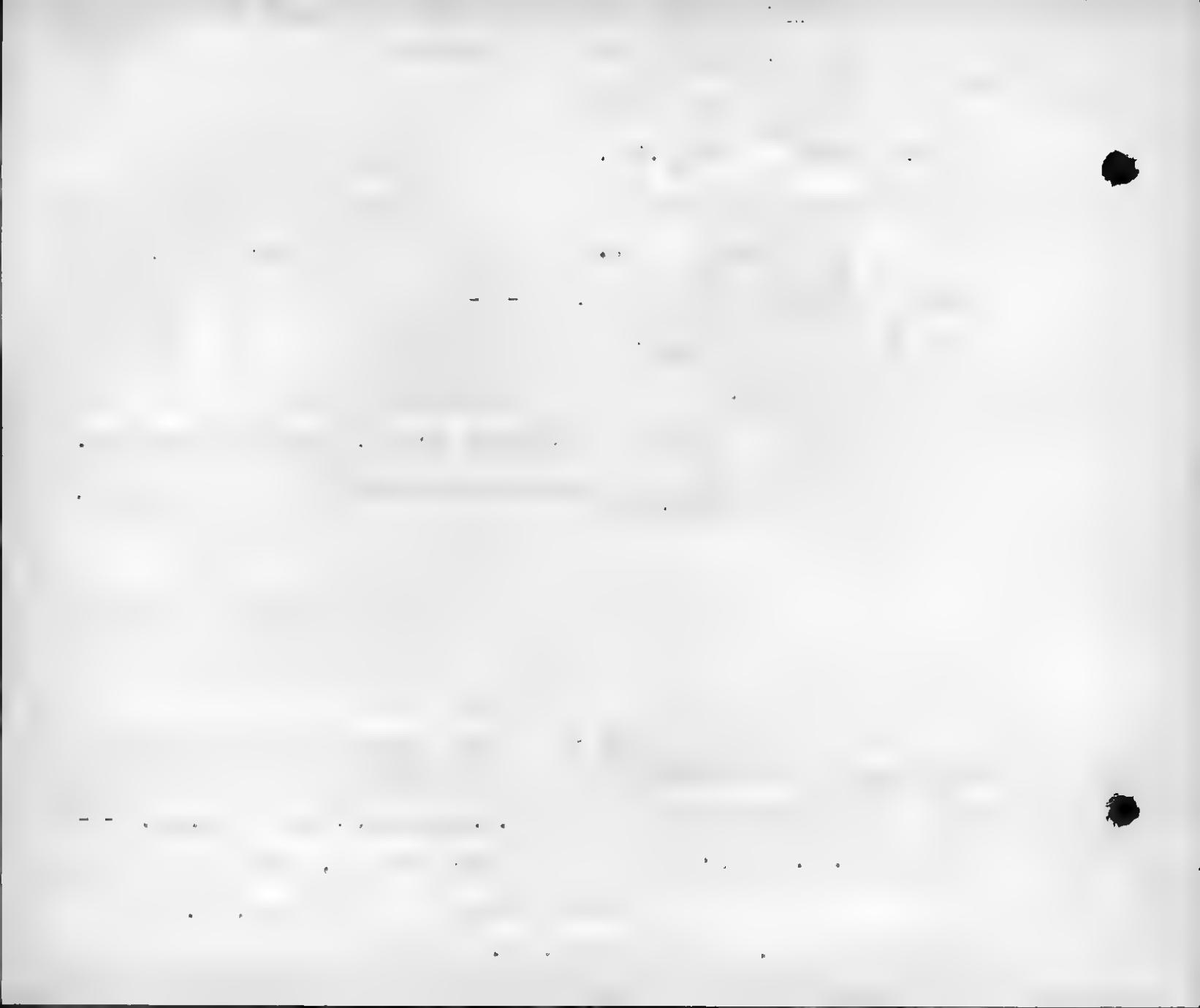
13649 CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 28 yrs. 6 mo. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1716 Byrd		d. DATE OF DEATH December 31		Month	Day	Year
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle J.	Last WILLIAMS	4. DATE OF DEATH December 31	Month	Day	Year	1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-21-96	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME George Williams			14. MOTHER'S MAIDEN NAME Agnes McGee					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rupture of myocardium secondary to infarction DUE TO infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) } DUE TO } (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) and that death occurred at 8:20 a.m. from the causes and on the date stated above						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 V.A.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 14, 1958 , to December 31, 1958 . I last saw the deceased XXXXXX XXXXXX XXXXXX XXXXXX and that death occurred at 8:20 a.m. from the causes and on the date stated above ACTUAL SIGNATURE W.M. Harris ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. 1-2-59 DATE SIGNED								
PHYSICIAN'S NAME (Type)		Acting Director, Professional Services						
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) 1/16/59		22b. DATE THEREOF 1/16/59		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		ADDRESS Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE JAN 9 '59		24b. REGISTRAR'S SIGNATURE Charles S. Krause		



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: This law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, it shall be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, it shall be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

VS AISC 155-104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**CERTIFICATE OF DEATH**

13638

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND Rising Sun	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND COUNTY Cecil Rising Sun
LENGTH OF STAY (In this place)		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (First) Howard Marshall Wilson		4. DATE OF DEATH Dec. 4 1958	
S. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 20, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE last birthday 79 yrs.
13. FATHER'S NAME Charles Wilson		14. MOTHER'S MAIDEN NAME Elizabeth Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 219-01-0395		17. INFORMANT & ADDRESS William McNamee, Rising Sun, Md
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
44. X IMMEDIATE CAUSE (A) Chronic Myocarditis 2 yrs.			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Hypertension GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 1, 1956, to Dec. 4, 1958, that I last saw the deceased alive on Dec. 2, 1958, and that death occurred at 5 A.M. from the causes and on the date stated above. SIGNATURE J. E. Decker M.D.			
ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Dec. 6, '58	NAME OF CEMETERY OR CREMATORIUM Brookview	LOCATION (City, town, or county) Rising Sun Md. 12-5-58 (State) Md.
24. REC'D BY REGISTRAR DATE DEC 8 '58	REGISTRAR'S SIGNATURE C. S. & K. M.		
75. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson, Rising Sun Md.			
ADDRESS			

1960-1961

1960-1961

1960-1961

1960-1961

1960-1961

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13633

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 8 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)				
f. STREET ADDRESS /		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Thomas	Middle S	4. DATE OF DEATH Wood Sr. December			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1900			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME William S. Wood		14. MOTHER'S MAIDEN NAME Mollie Crouch				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-5632	17. INFORMANT Mrs. Jane Putty Wood			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 757.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Spleno megaly, Cause undetermined		Address North East R.D. Md INTERVAL BETWEEN ONSET AND DEATH 6 days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12/8/58	20f. (City or town) 12/16/58	(County) ADDRESS (Street, city or town, state) John A. Fischer M.D. 162 W. MAIN ST. DATE SIGNED 12/16/58	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above.						
ACTUAL SIGNATURE John A. Fischer		PHYSICIAN'S NAME (Type) John A. Fischer				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/20/58	22c. NAME OF CEMETERY OR CREMATORIUM Harts Methodist Cemetery	22d. LOCATION (City, town, or county) North East (Rural) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph B. Grant	ADDRESS North East, Maryland	24a. REC'D BY REGISTRAR REC 22 '58	24b. REGISTRAR'S SIGNATURE Cecilia S. Kraus			

WYOMING STATE HIGHWAY - GALLIVAN

CERTIFICATE OF DESIGN

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

13640

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Md.		b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b 16 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital, D.O.A.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mabel	Middle York	4. DATE OF DEATH 12-23-1958
5. SEX F	6. COLOR OR RACE II	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1906
9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Wyatt		14. MOTHER'S MAIDEN NAME Effie Woods	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 160-00-0000	
17. INFORMANT George York, Elkton, R.D. 3, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Nephritis DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) PART III. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. TIME OF INJURY Hour a. m. 19 p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R.C. Dodson</i>	DATE SIGNED 12-24-1958		
EXAMINER'S NAME (Type) R.C. Dodson	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12-24-58	22c. NAME OF CEMETERY OR CREMATORIAL Daniel Cemetery	22d. LOCATION (City, town, or county) Clay Co., W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant	ADDRESS North East, Md	24a. REC'D BY REGISTRAR Arthur S. Knapp	24b. REGISTRAR'S SIGNATURE
VS. A15ME SM 2/57	DATE DEC 29 '58		

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